

Feedback

Senior  
level  
commitment

Incentives

# The Good System Guide

*A toolkit for developing  
performance-improving systems  
in healthcare organisations:*

*Pharmacies  
Mental health facilities  
Acute hospital settings  
General and dental practice*

Protocol

Teamwork

Smokefree  
environment

Training

Therapies

Resources

Local  
NHS  
Service  
info

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The toolkit is based on the resource, Smoking Cessation in Practice (SCIP) by West Yorkshire Smoking & Health.<sup>1,2</sup> Developed in 2000, it provided a framework for assisting healthcare organisations in improving performance in the provision of quality smoking cessation support.

The NHS Stop Smoking Services involved in its development included Bradford, Calderdale, Leeds, Kirklees and Wakefield.

The principles and system components outlined in this toolkit is applicable to any healthcare organization keen to help smokers to quit, eg general practice, pharmacies, acute hospital and mental health settings.

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## Rationale for improving delivery systems

Extensive research has shown that provision of quality cessation support is highly dependent on systems in healthcare organisations supporting providers in doing so. <sup>3-12</sup> This is true whether the setting is general or dental practice or an acute, mental or community settings. Mobilising large armies of clinicians and healthcare workers offers hope of driving down the number of tobacco users dramatically. But this requires changes in the system in which people work. <sup>4</sup>

### Quality smoking cessation is a 'system issue'

The importance of systems for quality smoking cessation was highlighted in a recent report which outlined a stage-based developmental framework. <sup>12</sup> The authors contend that the transition from one stage to the next is highly dependent on supportive systems.

**Stage 1: Haphazard care** - no system in place to encourage providers to ask, assist or offer quality smoking cessation; support varies greatly in quality and is dependent on the commitment of providers.

This was the situation in England prior to 2000 and the setting up the local NHS stop smoking services. Evidence based clinical guidelines had been published, however no guidance was given on the organisational systems needed to implement its recommendations. <sup>13</sup> The NHS services provided training in brief interventions to a wide variety of healthcare organisations but impact on provider behaviour was disappointing:

**Stage 2: Systematic screening** – a system in place supporting providers to ask smoking status and advising smokers to quit.

Smoking cessation in England moved into this stage when the Government introduced the voluntary Quality Outcome Framework (QOF) in which financial incentives were offered to providers for systematic screening of smokers. <sup>14</sup> This has increased assessment of smoking status but has not had a significant impact on increasing the number of smokers offered quality smoking cessation. Treatment continues to be haphazard; local NHS services continue to provide training in brief interventions and an increase in practitioners offering treatment as a result of training in brief interventions continues to be disappointing.

**Stage 3: Systematic treatment** - a system in place supporting providers to offer quality smoking cessation support to smokers, especially those motivated to quit.

The Quality Outcomes Framework has added *supporting smokers to quit* as an incentivised activity. However there still is no guidance on how to improve performance in provider organisations. Smoking cessation experts would prefer that a system is in place requiring GP practices to refer patients to the local NHS stop smoking service in order to receive QOF payment.

**Stage 4: Population approach** – a systems in place ensuring that all smokers are offered quality cessation support. This stage focuses on all smokers, not just those wishing to quit. It does not depend on patients visiting a healthcare organization but instead on outreach activities such as direct marketing to reach smokers. The Department of Health (DH) is now in this stage with its 2008-2010 campaign aimed

at triggering quits attempts in routine and manual smokers. <sup>15</sup> Amongst its outreach activities is encouraging healthcare providers to offer cessation support.

## **What is this toolkit designed to do?**

This toolkit is designed to be a short, practical resource on establishing efficient and effective systems for delivering stop smoking support in any healthcare setting. Offering brief advice to quit is the single most cost effective preventive action that a practitioner can undertake. <sup>16</sup> Requiring a small investment of time, it is the “Gold Standard” of preventive interventions.<sup>17</sup> The overall goal of the toolkit is to develop systems that support healthcare providers to ‘go for gold’ with all smokers.

## **Blame poor performance not on individuals but on inadequate systems**

This toolkit aims to improve performance not by focusing on 'poor performers' but on 'poor systems'. According to the NHS Modernisation Agency, it is rarely individuals who are the problem when something is not happening. <sup>18</sup> Healthcare professionals attending training in brief interventions do so with good intentions to put their new knowledge and skills into practice 'back at the office'. But good intentions do not guarantee that changes in behaviour will automatically occur. <sup>19</sup>

The US Preventive Services Task Force found that tobacco cessation counseling has the lowest rate of delivery even though it is a high priority service.<sup>20</sup> It undertook a systematic review of research to identify strategies increasing the number of healthcare providers discussing smoking with patients and in patients quitting. <sup>21, 22</sup>

### **Healthcare provider training alone**

**Conclusion:** There is *insufficient evidence* to determine the effectiveness of provider education alone in increasing the number of people who quit smoking. Though education alone is not harmful, no benefits have been identified. Simply training clinicians in brief interventions is insufficient to change practitioners' behaviour.

### **Provider system interventions alone**

**Conclusion:** There is *sufficient evidence* of effectiveness of provider system interventions in increasing the number of providers who advise their clients to quit smoking.

### **Healthcare provider systems and provider education**

**Conclusion:** There is *strong evidence* of effectiveness of multi-component interventions including provider systems and provider education, with or without patient information, in increasing the number of providers who advise their clients to quit smoking and in increasing the number of clients who quit. The authors conclude that education and training alone is not the answer to changing practitioner behaviour. Good systems must be in place to support health professionals in providing brief interventions.

Training alone is unlikely to be a useful investment, unless linked to organisational change. Training that target only healthcare professionals and not the systems in which they practice will be limited its effectiveness and reach. <sup>11</sup>

## **Improvement lies with changing the system**

The Denning rule says that approximately 85% of improvement opportunities lie with changing the system, the remaining 15%, with changing individuals. <sup>23</sup> A supportive infrastructure that both actively and passively support clinicians in offering brief

interventions has been shown to increase the number of quit attempts. 7

## A quick guide to developing systems in practice

### Developing NHS Stop Smoking service's skills and confidence

- Attend SCIP introductory workshop; include as many members of the team as possible. SCIP is more successful with 'whole team' involvement.
- Arrange a meeting with the team to discuss and agree an action plan. See Appendix for sample action plans.
- Analyse service capacity and skills within the team for developing systems in healthcare organisations.
- Identify training needs of staff in negotiation skills and feeling confident in working with senior management staff and teams.
- Arrange for feed back from practice visits at team meetings to share experiences.
- Identify opportunities to increase awareness of the importance of performance improving systems with opinion leaders, PCTs commissioners, director of public health, director of performance management.
- Arrange for inclusion of SCIP in service level agreements.

### Identifying the target group

- Identify target group, eg GP practices, acute settings, dental practices, frontline staff, pharmacists etc.
- Prioritise specific teams to target; suggested criteria:
  - High smoking prevalence, low referrals, low success rates.
  - Capacity and skill set of the SCIP staff in service development
  - Aim for teams with high credibility with the target audience to set an example for other teams
- Allocate staff to specific teams. A typical plan is to assign staff to a locality area, responsible for supporting healthcare organisations, eg GP practices, dental practices, pharmacists etc within the area.
- Gather information about the targeted practices, eg
  - Attitude of senior management towards preventive activity
  - Number of medications prescribed vs numbers referred for support
  - QoF reimbursements
  - Experiences of other colleagues who provide services to the practice
- Set up a database of *Team facts*. Include relevant information about senior management, gatekeeper, opinion leaders, team motivations, problematic issues.
- Practice your presentation with your fellow staff members before your first visit with a practice team

## **Working with a team**

- Contact the team's 'gatekeeper' and ask for 10 minutes at a team meeting. If more time is requested, you are risking a negative response. At the end of your presentation, allow time for questions. If the team is keen, it will give you more time.
- In preparing your presentation, identify those who really need influencing. Key to success at selling a product is meeting the needs, wants and feelings of the decision makers. Do not mention the service's need to achieve targets unless someone else brings it up. If it is brought up indicate that targets are a low priority; higher on the list is to help the team improve their support for smokers.
- Be passionate about the 'product' you are offering, eg it will help achieve the team's agenda with a minimum amount of time and effort. Redirect blame for 'poor performance away from 'poor performers', and instead onto gaps in the system.
- Respect time pressures typically felt by health care providers; identify ways of making the improvement process as effortless as possible.
- At the end of the meeting arrange a further meeting with a working party made up of team members to assess current system in place and plan improvement

## **Future meetings**

- Before making any improvement, first assess the current system to identify strengths and gaps in the system.
- Aim for 'quick successes' to maintain team enthusiasm.
- Arrange for training in brief advice to occur just before the system goes 'alive'. If training is too soon in the process, the team may forget the necessary skills.
- Provide resources, eg posters to promote the stop smoking services; NHS service business cards for staff to give to smokers about the local service, information about bonafide and bogus therapies.
- Identify how the team wants to audit their activities and implement a system for feedback to the team about the outcome of activities.
- Clarify your time limited input. Eventually your role will change from active involvement to ongoing reinforcement.
- Pilot the system for 6 weeks to 2 months to iron out any potential problems

## **Reinforcing activities**

- Plan an action plan to reinforce the team's commitment to providing smoking cessation support. Ongoing reinforcement is vital for sustainability.
- Maintain regular face to face contact with the team to show that you are keen to support them.

- ❑ Arrange update sessions with the team to maintain skills, confidence and commitment in quality smoking cessation.

# Brief interventions

**Offering advice and support to stop smoking is the single most clinically and cost effective preventive action that a clinician can undertake.**

**No other preventive intervention produces such a powerful health result with such a small investment in time. It is the “Gold Standard” of preventive interventions. <sup>17</sup>**

## What is the aim of a brief intervention?

The aim of a brief intervention is to increase smokers' motivation to stop, with a secondary aim of giving practical advice about quitting. The National Institute of Health and Clinical Excellence have issued guidance on brief interventions: <sup>25</sup>

Brief intervention for smoking cessation can take between 5 – 10 minutes and includes one **or** more of the following depending on time available:

1. Simple opportunistic advice to stop
2. An assessment of the patient's commitment to quit
3. An offer of pharmacotherapy and /or behavioural support
4. Provision of self-help material and referral to more intensive support such as the NHS stop smoking service.

## Why should all health professionals give brief interventions?

Advice from a health professional is a common prompt for smokers to make a quit attempt. When stop smoking messages are received from *many* healthcare providers, motivation is increased. <sup>24</sup> NICE recommends that all professionals give brief stop smoking messages to all smokers (unless there are exceptional circumstances when it might be inappropriate to discuss smoking). <sup>25</sup>

***If all healthcare providers gave empowering cessation messages to all smokers, the impact on smoking prevalence would be greater than doubling the price of cigarettes.*** <sup>26</sup>

Brief intervention by a clinician is especially effective. Doctors are key agents in smoking cessation as they have access to thousands of smokers every year through their consultations, have an ideal opportunity to boost a smoker's confidence in quitting and are effective change agents. <sup>27</sup>

No other preventive activity by a doctor produces such a positive effect on the quality and length of life with such a small investment of time. It can lead to reported quit rates of 2-3% higher than smokers who did not receive brief advice. <sup>24</sup> The combination of a clinician's brief advice combined with behavioural support and pharmacology can result in quit rates up to 20%. <sup>28</sup>

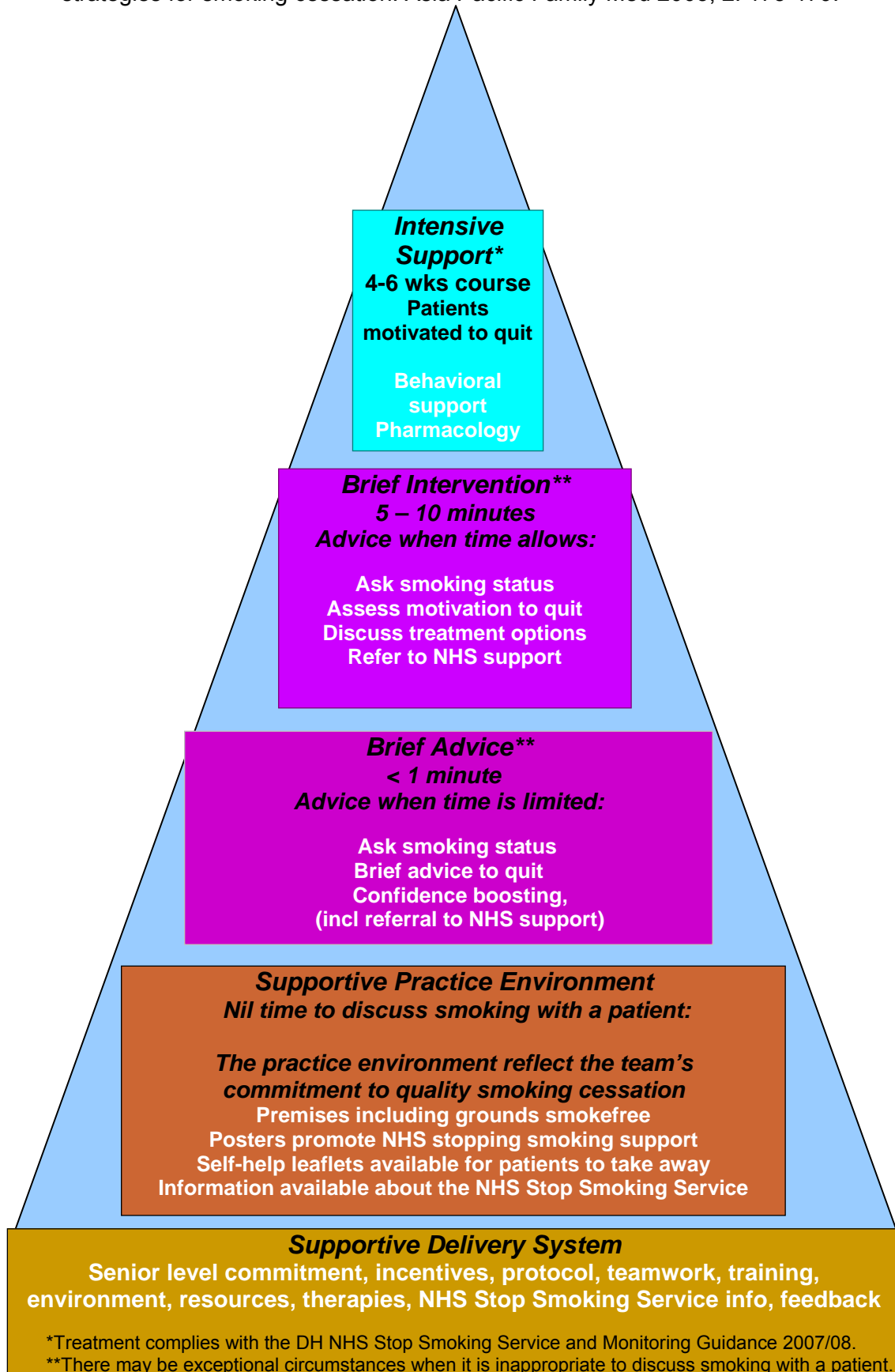
## What can a health professional do when time is very limited?

A five point agenda has been suggested as a holistic smoking cessation counseling approach: Ask, Advise, Assess, Assist and Arrange. <sup>24</sup> However many healthcare organisations are not able to delivery all five points due to resource and time constraints. The brief intervention recommended by NICE can take up to 10 minutes. <sup>29</sup> This can prove impractical for busy health professionals, especially clinicians for whom the typical time available in a consultation for preventive advice averages less than a minute. <sup>7</sup>

A tiered approach based on the 'less is more' concept has been suggested as a cost-effective and realistic way forward. <sup>4, 7</sup> See graph overleaf.

# Tiered Approach to Stop Smoking Support

Adapted from Litt J, Ling M-Y, McAvoy B. How to help your patients quit: practice-based strategies for smoking cessation. *Asia Pacific Family Med* 2003; 2: 175-179.



## A tiered approach to stop smoking support

The Tiered Approach to Stop Smoking Support is based on the population-wide *'less is more'* approach endorsed by leading international organisations due to its ability to reach significant numbers of smokers, positive impact on public health and reduction in disease rates.<sup>30-32</sup> The approach ensures that available resources reach as many smokers as possible while ensuring that only the few who would most benefit are given resource-intensive interventions.

In reality it advocates 1) brief advice involving minimal resources for all smokers, 2) more resource-intensive interventions for those with or at high risk of smoking related diseases and 3) highly resource-intensive interventions to the motivated few.

The approach highlights the importance of supportive delivery systems and practice environments to reinforce active support from healthcare providers. It takes into consideration the limited time that clinicians have to discuss preventive issues and outlines the most effective advice in the time that is available.

- **Supportive delivery system**

The base of the pyramid describes the ten components essential for an infrastructure supporting healthcare providers to provide quality smoking cessation support.

- **Supportive practice environment**

The practice environment should reflect a smokefree norm so that when there is no time to discuss smoking, smokers are still given the impression that stopping smoking is a credible activity, that the team is committed to helping smokers to quit and that there is friendly support available.

- **Brief advice**

When time is very limited, the ABC approach outlines what a clinician can effectively be do in less than a minute to encourage smokers to make a quit attempt. Though the more time spent in encouraging smokers to quit, the greater the impact, clinicians typically have less than a minute of 'disposable' time to raise issues relevant to the patient's overall health.<sup>31,33</sup> The 30 second stop smoking advice for clinicians described below is advocated by the US Smoking Cessation Leadership Centre.<sup>34</sup>

- **Brief intervention**

When there is more time available, eg from 5 to 10 minutes to discuss smoking with a patient, the clinician should offer the brief intervention recommended by NICE:

- Simple opportunistic advice to stop
- An assessment of the patient's commitment to quit
- An offer of pharmacotherapy and /or behavioural support
- Provision of self-help material and referral to more intensive support such as the NHS stop smoking service.

Personalising the reason for quitting with the patient's health problems is especially important for those with or at high risk of smoking related health problems.

- **Intensive support**

From 5- 10% smokers will be highly motivated to quit smoking as a result of receiving their clinician's encouragement to quit. They should be offered intensive behavioural support and pharmacology. The treatment offered should comply with the NHS Stop Smoking Service and Monitoring Guidance 2007/08.

See page 39 for a description of the above three levels of stop smoking support.

## Clinicians 30 second brief advice

The key to getting clinical colleagues on board with encouraging smokers to quit is to advocate advice which is as brief as possible. <sup>12</sup> A resource has been developed identifying what can be done in 30 seconds. Described as the ABC approach, it advocates three steps which can be easily delivered in a short period of time:

- **Ask** about smoking status
- **Brief** advice to quit
- **Confidence** boosting in ability to quit, including referral to NHS support

Smokers are aware of the dangers of smoking and do not need to be reminded of why they should quit. Instead of discussing the dangers of smoking to health, the most effective action that a clinician or healthcare provider can do is devote most of the 30 seconds in boosting confidence in quitting.

The promotion of repeated cessation treatment is important in assisting relapsed smokers attempt to quit again. <sup>35</sup> Studies have found that over half of relapsed smokers report a higher interest in attending cessation services again. <sup>36</sup> Healthcare providers should encourage as many quit attempts as possible in the hope that each attempt is another 'roll of the dice'.

**CLINICIAN'S 30 SECOND STOP SMOKING ADVICE** **NHS**

*IT COULD JUST TAKE 30 SECONDS TO GIVE SOMEONE THE CONFIDENCE NEEDED TO QUIT!*

When you only have 30 seconds, the most effective thing you can do is ABC: **Ask** and record smoking status; **Brief** patient about the effectiveness of local stop smoking support; express **Confidence** in their ability to stop. Brief advice is more effective when it is part of a practice cessation strategy (**QOF points**). Your local NHS stop smoking service can help develop a strategy.

- Smokers expect to be asked about smoking as it shows clinician's concern about their overall health.
- If clinicians don't mention smoking at every consultation, patients are given the impression that it is not affecting their health and so are less likely to make a quit attempt.
- Most smokers have to quit *multiple* times before stopping permanently. The most effective thing that a clinician can do is to continue to support smokers in their efforts to quit.

**ASK**  
Ask and record smoking status:  
**smoker • ex-smoker • non-smoker** **QOF POINTS\***

**BRIEF ADVICE**  
"Stopping smoking is the best thing you can do for your health!"

**CONFIDENCE BOOSTING** **QOF POINTS\***

*"I know you can quit. I recommend that you see our local NHS Stop Smoking Service. You are up to 4 times more likely to stop if you do. Many of my patients referred to the Service have quit. It can give you tips on dealing with cravings, stop smoking medication and help in staying motivated."*

To give your patients the best chance at success, fax or email a referral to the NHS Stop Smoking Service.

\* Ensure your practice has a system in place to audit referrals to the NHS Stop Smoking Service and QOF payments.

**SMOKEFREE**

## ABC addresses major barriers to brief interventions

<b>Fear of overrunning the consultation</b>	It takes less than a minute to deliver.
<b>Lack of financial reimbursement</b>	It fulfils requirement for QOF points.
<b>Fear of irritating patients</b>	Patients prefer healthcare provider to ask about smoking as it shows concerns for their overall health. <sup>32-34</sup>
<b>Patients not interested in quitting:</b>	Three out of four smokers want to quit; if a GP does not mention smoking during a consultation it gives the impression that smoking does not affect health.
<b>Lack of confidence in discussing smoking</b>	The approach focuses on the positive support available, thereby avoiding complex discussions often triggered when assessing motivation to quit
<b>Patient's fear of failure</b>	Many smokers do not make a quit attempt due to a fear of failure. Increasing awareness of the type of support available from the NHS Stop Smoking Service can ease fears.
<b>Tendency for patients to trouble telling</b>	Focusing on the support available deflects tendency for some patients to elaborate on current lifestyle barriers as a means of reducing the importance of quitting.

### Support for the ABC approach from NHS Yorkshire & Humber

The following is a letter to GPs in Yorkshire & the Humber from the Regional Director of Public Health, Professor Paul Johnstone, NHS Yorkshire & the Humber encouraging delivery of brief interventions using the ABC approach.

*"I am writing to you ahead of World No Tobacco Day on 31 May 2008 to highlight the vital importance of your role in helping people to stop smoking. Despite more smokers quitting than ever before, smoking remains the leading preventable cause of premature death and of health inequalities in our region.*

*Tobacco kills nearly 10,000 people every year in Yorkshire and the Humber. Nearly three out of four smokers say they want to quit. The evidence shows clearly that advice from a General Practitioner is very powerful in influencing smokers to make a quit attempt. Many of those quitting through NHS services will have been motivated to do so by your advice.*

*I would like to thank you for this, but would also like to ask you to go further. The NHS Next Stage Review in Yorkshire and the Humber<sup>1</sup> clearly identified brief intervention in primary care as a proven method of encouraging smokers to quit.*

*My challenge is that you see every consultation as an opportunity for brief intervention. This need not take long. The attached advice has developed in our region but endorsed nationally. It highlights that the most effective action that a general practitioner can take is boosting a patient's confidence in quitting. This can be done in 30 seconds.*

*I hope that you will take up this challenge as individual clinicians, as practices and as PBC Consortia."*

<sup>1</sup>

## Are clinicians' reasons for not discussing smoking justified?

Common reasons for not delivering brief interventions are listed below. However, Revell and Schroeder suggest: "*There is no valid reason for a healthcare provider in failing to give the most powerful health promoting intervention there is*".<sup>4</sup>

### It's a waste of time

Provider advice delivered in routine practice settings has a substantial effect on the success rate of smoking cessation among smoking patients. The provision of advice consistently to all smoking patients may be more effective than doubling tobacco tax and, in the longer run, likely to outperform tobacco control policies such as banning smoking in private workplaces.<sup>25</sup>

### Lack of knowledge about helping smokers to quit

The only knowledge that a health care provider needs is that *people are up to four times more likely to quit if they have behavioral support from an experienced advisor and pharmacological therapy*. There is no need for an in depth knowledge of stopping smoking as a trained stop smoking advisor will be able to answer complex questions.

### Lack of significant financial incentive

Providing brief advice to stop smoking is a basic duty of care activity, requiring healthcare provider to do the best for the people who have entrusted them with the care of their health.

### Patient unlikely to quit

Smoking is a true addiction, a chronic relapsing disease in which the addicted smoker usually has to make multiple quit attempt, eg up to 14 times, before being successful.<sup>37</sup> Relapsing is a natural part of the quitting process.

The most important thing a healthcare provider can do is to continue encouraging smokers to make quit attempts, and not give up on them if the attempt is not successful. With encouragement from a healthcare provider, smokers increase their chances of quitting with every attempt.

### Smokers do not want to quit

Smokers can quickly change their attitude toward quitting...all it may take is an empowering message from their healthcare provider.<sup>38</sup> Most smokers say they would like to stop and they want encouragement to do so from those they have entrusted with their health.

### Afraid of irritating smokers

Most smokers see their family doctor as a key source of advice and influence about quitting smoking. Smokers, even those who have no desire to quit, prefer that their healthcare provider advises them to quit because it shows their concern for the individual's overall health.<sup>39-41</sup> When a healthcare provider does not mention smoking, it gives the impression to the patient that smoking is not affecting their health.

### Takes too much time

Though the more time spent encouraging a smoker to quit increases the chances of success, even a 30 second message can be effective in encouraging quit attempts.<sup>31</sup> No other preventive intervention produces such a powerful health result with such a small investment in time.<sup>17</sup>

# health works

// Staff Newsletter // February 2008

Rotherham **NHS**  
Primary Care Trust



## Stop Smoking Referrals

February 2008

**NHS**  
The NHS in Rotherham

### Dear Colleague

I am writing to ask all staff – particularly those of you who work directly with patients – to take an extra step to help improve the health of your patients, friends and relatives.

The best thing anyone can do to improve their health and their life expectancy is to quit smoking and sometimes all people need is a little encouragement and to know where they can go for advice and support.

If every member of staff that has direct contact with patients was to refer just one person a month to the Rotherham Stop Smoking Service it would make a significant impact on the health of the local population. Stopping smoking can add another ten years to a person's life!

I am not asking you to be an expert on smoking cessation but to simply raise the issue of the health benefits of stopping smoking and referring patients to the Rotherham Stop Smoking Service for expert support and advice.

The following **ABCD** approach is an evidence based model for raising the issue with smokers and helping them quit:

**A**sk - Determine and record the patient's smoking status

**B**rief - Tell them that stopping smoking is the best thing you can do to improve your health and add ten years to their life.

**C**onfidence - Express your confidence in their chances of quitting – they are up to four times more likely to quit with the help of the service.

**D**irect - Direct patients/clients to the Rotherham Stop Smoking Service by filling out a referral form (supplies from Rotherham Stop Smoking Service) or ringing the service on 01709 302444.

Stopping smoking at any age increases your life expectancy, provided you stop before you develop cancer, heart disease or other serious illnesses. But even if damage has already been done, you can still benefit from stopping smoking.

I would like to ask every member of staff to try to refer at least one patient to the Service before No Smoking Day on Wednesday 12th March and at least one patient a month thereafter.

For more information contact the Rotherham Stop Smoking Service on 01709 302444 or visit [www.smokefreerotherham.co.uk](http://www.smokefreerotherham.co.uk).

With thanks

Andy Buck  
Chief Executive  
Rotherham Primary Care Trust



**SMOKEFREE**  
ROTHERHAM

# Delivery systems

**Approximately 85% of opportunities for improvement lie with improving the system while 15% lie with changing individuals.** <sup>22</sup>

**Without a supportive infrastructure, practitioners can not be counted on to assess and treat tobacco use reliably.** <sup>24</sup>

## What are the overall aims of a system approach?

A system approach aims to ensuring the delivery of quality smoking cessation. To achieve this requires the whole team feeling a part of the whole scheme in contrast to one or two individual working in isolation. <sup>18, 42</sup>

## What are the components of a delivery system?

Ten components have been identified as essential for a delivery system. <sup>1,2</sup> Each component is a link in a chain. If one link is missing, the whole system will be weakened.

### 1. Senior level commitment

Improvement in a system is highly dependent on commitment from senior members of the team.

### 2. Team incentives

Strong incentives to do so need to be felt by everyone in the team in order for stop smoking interventions to be delivered consistently. The strongest incentive relates to the team wanting to do the best for their patients, ie providing Gold Standard Care.

### 3. Protocol

A detailed protocol ensures that all team members are clear on who is doing what. It should be tailored to the needs of the team and their desire to improve patients' health.

### 4. Teamwork

Everyone in the team needs to be involved in delivering smoking interventions in some way. When stop smoking support is the responsibility of only one or two people in the team, the system will be compromised and sustainability is less likely.

### 5. Training

The whole team should be trained in brief interventions. The training should be provided just before skills are needed, be practice based or utilises existing opportunities such as continuing professional development sessions. <sup>49</sup>

### 6. Environment

The working environment should reinforce smokefree messages provided by the healthcare providers. The entire site should be smokefree and both the reception and practice offices display promotional materials about the stop smoking support available.

### 7. Resources

Appropriate patient information needs to be conveniently available and managed. The team should know where leaflets are stored and which leaflets meet diverse needs.

### 8. Therapies

The team should be aware of effective and bogus therapies so that they can help patients make informed choices about effective stop smoking aids.

### 9. Local NHS Stop Smoking Service

Information should be conveniently available about the NHS Stop Smoking Service, its success rate, types of support available and where clinics are held.

### 10. Reinforcing feedback

Ongoing regular feedback about the impact of the system on patient satisfaction and on smoking behaviour is key to the team's continued adherence to the system.

## Components of a sustainable delivery system

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### Influencing healthcare provider behaviour

Implementing a sustainable delivery system will potentially require changes in healthcare provider behaviour. Influencing a team's behaviour involves three stages: <sup>43</sup>

- **Stage 1: Agreement** - factors *persuading* a team to perform a certain task:
- **Stage 2: Adoption** – activities *empowering* a team to perform a certain task include:
- **Stage 3: Adherence** - activities *rewarding* a team to continue to provide a certain task:

## Stage 1: Agreement (gaining commitment)

The first stage is agreement, ie gaining commitment, especially from senior level colleagues. The following continuum identifies attitudes that may be encountered by senior level colleagues.<sup>18</sup>

- Active resistance
- Blocking/sabotage
- Passive resistance
- Scepticism
- Disconnection
- Lack of interest
- Neutral / ambivalence
- Curious scepticism
- Acceptance
- Engagement
- Active participation
- Influencing others ie 'a champion'

Reason for negative attitudes are generally due to lack of time, lack of confidence in discussing smoking, lack of supportive systems, fear of irritating patients, feeling that patients do not want to quit and that advising patients to quit is a waste of time. <sup>3-10</sup>

### How to change negative to positive attitudes

Appealing to both the hearts and minds is a proven way of influencing attitudes. Failing to appeal to the emotional side of people (what they think and what they feel) tends to doom any change process. <sup>44</sup>

People change what they do *less* because of information shifting their thinking but *more* due to its influence on their feelings. <sup>44</sup>

Harvard Business School

A heart and mind approach involves social marketing principles:<sup>45</sup>

- o Identifying barriers to the desired behaviour change required by the team
- o Identifying potential benefit the team will obtain from the desired behaviour change
- o Determining the *competition* for the team to continue its current vs the desired behaviour
- o Insuring that the benefits of the desired behaviour outweigh its associated costs

### Tips on a 'hearts and mind' approach <sup>39</sup>

#### Think about your audience

Ask yourself... who are the people you really want to influence? Identify information that is relevant to the target audience, ie that they easily understand but most important that they can do something about and is something that will meet patient's needs.

Clinicians prefer to refer their patients to a personalised service. In your presentation emphasise the way in which the specialist service personalised its support to smokers.<sup>46</sup>

Set up a database of Team Facts, containing relevant information about things that make the team tick and that may appeal to their hearts and minds, eg team

personalities, the gatekeeper, the opinion leaders, what motivates the team, awkward questions that have been raised in the past, problem issues. Include views & experiences of other colleagues who provide services to the team

### **Make your presentation matter**

Not everyone responds well to elaborate graphs and charts. Don't endeavour to 'dumb' down information just to get people to take notice, but at the same time neither do you want people to ignore it because it is too complex or completely impenetrable.

### **Test your approach**

Test your approach with other members of your team, a friendly GP or dentist or whoever is the target audience before you use it formally.

### **Appeal to people's emotions**

Failing to appeal to the emotional side of people, (what they think and what they feel) is likely to doom any change process. Do not just present your facts but look for a story the data is telling you. Here are things that may appeal to healthcare providers' emotions:

- belief that prevention is an important part of their role, and is consistent with their professional and practice goals
- belief that prevention can be delivered effectively and efficiently, and that it requires minimal amount of time and effort
- realise that the benefits are worthwhile for both GP and patient
- have the relevant skills, time and resources
- patients will be receptive to the advice

### **Tips to increase your confidence in negotiating with a team:**

- Have a 'mantra' to say to yourself when feeling apprehensive:
  - Brief advice to stop smoking is the Gold Standard of preventive interventions.
  - I have every right to encourage healthcare workers to tackle smoking.
  - I can make it easier for a team to meet their preventive role and it will not take excess time or require in-depth knowledge
  - I have the support of DPH, PCT performance management lead, other GPs.
  - Smoking is the biggest public health problem we face; it is everybody business in the NHS.
  - I have had many successes with other teams.
  - Helping someone stop smoking is well worth the effort, eg clinician advice to quit produces a numbers need to treat (NNT) of 50 to save one life year compared to the NNT for statins in primary care (107).<sup>47, 48</sup>
- Feel passionate about helping smokers to stop. When you genuinely believe that the product you are offering is the '*best thing since sliced bread*', you will not have any problem 'selling' what you have to offer.
- Get the support of key stakeholders for what you are doing, eg PCTs commissioners, director of public health, director of performance management.
- Identify opinion leaders willing to act as SCIP champion actively promoting it through personal example.

## Using body language to appeal to 'heart and minds'

Your body language expresses what is going on inside your heart and your mind, giving the audience clues as to whether the words you are saying are consistent with what you are really feeling. It will determine to a significant extent the quality of a communication.

It is estimated that up to 80% of a message is communicated through body language while less than 10% from the actual words used. Here are some tips to ensure your body language does not let you down:

### Facial expression

Be aware of your facial expression. Smiling is one of the strongest tools, however, be beware of smiling too much as it may give the impression that you are overly anxious. Keep your expression relaxed and friendly; smile when appropriate.

### Eye contact

Maintain good eye contact with the person(s) that you most want to influence, especially when you want to make an important point. But remember to have eye contact with other team members. Avoid staring, glaring or looking out the window. Instead look directly at a person with a sense of confidence but without it being overbearing or threatening in nature.

### Hand gestures

Hand gestures will make you seem enthusiastic and committed to your topic. But making too many gestures can make you appear nervous and tense. Keep hand gestures above the waist and palms up. Don't place your hands in front of your mouth as it looks as if you are trying to conceal something.

### Posture

Keep your head level both horizontally and vertically when you want your message to be taken seriously. When listening tilting your head from left to right at different points of the conversation will make you look like your listening.

### Personal space

Keep a proper distance from others is vital. Being too close can make people feel uncomfortable while being too far away may make people feel rejected.

### Vocal cues

Lengthy pauses during your presentation will give the audience the impression that you are uncertain about your topic. Sounds such as 'uh', 'um' and word repetitions will distract the audience.

### Summary

Remember to smile when appropriate, have good eye contact, use open hand gestures and have good posture to increase your self-confidence and to get your message across to your audience in a powerful way.

## Arrange a meeting with the whole team

Contact the team's 'gatekeeper' and ask for 10 minutes at a team meeting. If you ask for more time, you are risking a negative response. At the meeting, allow time for questions. If the team is keen, it will give you more time at the meeting.

## At the team meeting

Building a receptive climate for improving practice systems. Improvement will not happen without the energy and enthusiasm of the team. Here are some tips:

- ❑ Ask the team what it wants to do for smokers; encourage the team to want to do the best for each individual patients; anything less implies that it is acceptable for patients to receive care below the agreed standards.
- ❑ Indicate that you are keen to help them team supports patients in quitting; do not mention service targets unless the team bring it up. If targets are mentioned, indicate that they are a concern but it is the last on your list of priorities. Your first priority is improving performance, not on improving 'poor performers'.
- ❑ Establish your credibility; do not be apologetic for taking up their time; express confidence that the 'product' that you are offering will have a positive impact on performance, and that it make their job easier and improve patients' health.
- ❑ Redirect the blame for inconsistencies in delivery of stop smoking support away from individuals in the team, and instead onto gaps in the system.

## Identify a working party / a programme coordinator

Ideally ask for members of the team to be on a working party to assess the current system in place and identify areas for improvement. The ideal working party includes a member of the senior management team, operational lead, practice manager, IT staff and a programme coordinator.

If time constraints and other commitment preclude a working party, ask for one member of the team to be the designated coordinator and the main contact for the facilitator.

## Meeting outcome

At the end of the meeting, the ideal result is that the whole team shows commitment towards improving its performance in ensuring that patients are offered the best treatment for the greatest chance of success.

## Further reading

- Engaging doctors in tobacco control. Tobacco Control Strategy Planning, companion guide number 2. American Cancer Society, International Union Against Cancer (UICC): [www.uicc.org/programmes/tobacco/fact-sheets/18fact.shtml](http://www.uicc.org/programmes/tobacco/fact-sheets/18fact.shtml)
- Putting prevention into practice – guidelines for the implementation of prevention in the general practice setting, 2<sup>nd</sup> edition. Royal Australian College of General Practitioners, July 2006. ISBN:- 13:9780 86906 274 6.
- [www.modern.nhs.uk/improvementguides](http://www.modern.nhs.uk/improvementguides): Managing the human dimensions of change; Building and nurturing a culture of improvement.
- Tackling the smoking epidemic. International primary care respiratory group: IPCRG International guidance on smoking cessation in primary care. [www.theiprcg.org/smoking/index.php](http://www.theiprcg.org/smoking/index.php).

## Stage 2: Adoption (Enabling / taking action)

Here are tips for implementing changes in the system:

### ❑ **Assessing the current system in place**

Find out and build on what already is working well. Assess the current system is important to identify what components are already in place to boost the team's morale and which are not to identify where more work is needed for best effect.

Two checklists for assessing the current system are available:

- Quick tick version
- Comprehensive version

It is better to use the comprehensive version as it will give you better quality information on the degree to which each component is in place.

The assessment checklist can be used as a basis for:

- Semi-structured interviews with the working party
- Informal discussions with the working party
- A whole team activity, ie each member complete the checklist

### ❑ **Involving the team**

Once the assessment of the current system is completed, analyse the results and feedback to the team. Let the working party identify areas needing improvement. People feel better about change when they are involved.<sup>42</sup> So encourage as many of the team members as possible in identifying what needs to be improved.

### ❑ **Developing a written protocol**

A detailed written protocol identifying the tasks of each team member is critical. It should be as detailed as possible so that everyone knows what their role is and delivering brief interventions become a whole team approach. See Templates

### ❑ **Identifying quick successes to maintain enthusiasm**

Identify areas for quick successes to maintain enthusiasm, eg putting up posters promoting the support available, buying a filing cabinet for storing leaflets, developing an automated means of recording smoking status.

### ❑ **Arrange 'just in time' training**

Arrange training for the whole team in brief advice just before the skills are put to use. If training is provided too far ahead the skills may be forgotten.

### ❑ **Use scenarios to test your change strategy**

Walk through or act out the idea for the system improvement to get feedback from the team before implementing any changes. This will give the team a real feel for whether the proposals will make any real improvement.

### ❑ **Making best use of limited healthcare providers' time**

Identify the impact on healthcare providers' time and steps to ensure that the time that is required is used to best advantage. Due to resistance of healthcare providers to attend meetings intruding on their primary role of providing patient care, alternative methods of communicating with the team should be identified.

### ❑ **Piloting the system**

Once a proposed system is determined, pilot it to iron out problems before 'rolling it out'. This allows time for the team to reflect on the system to determine impact on existing workloads and on patients' reactions.

Checklist - Taking Action	Timescale
<input type="checkbox"/> Prepare for team meeting; gather relevant information on the team and its smoking intervention activity <input type="checkbox"/> Organize information into a folder <input type="checkbox"/> Put together a pack of resources (posters, service information, protocol template) to give to the team at the first meeting	
<input type="checkbox"/> Attend team meeting <ul style="list-style-type: none"> <li>• Introduce rationale for brief interventions and a delivery system</li> <li>• Gain commitment of whole team, esp senior members</li> <li>• Identify coordinator</li> <li>• Arrange meeting with coordinator / working party</li> </ul>	
<input type="checkbox"/> Meet coordinator / working party <ul style="list-style-type: none"> <li>• Complete system assessment questionnaire</li> <li>• Feedback results of assessment</li> <li>• Identify initial priority areas for improvement</li> <li>• Identify gaps in resources; explain local ordering system</li> </ul> <input type="checkbox"/> Arrange meeting between coordinator to draw up protocol	
<input type="checkbox"/> Meet coordinator / working party to draw up protocol <input type="checkbox"/> Ensure staff are booked onto training where appropriate <input type="checkbox"/> Ensure all resources are ordered <input type="checkbox"/> Deliver in house brief interventions training	
<input type="checkbox"/> Write up and communicate protocol to all staff <input type="checkbox"/> Ensure all staff understand their tasks <input type="checkbox"/> Review system to ensure that all ten components are in place <input type="checkbox"/> Arrange meeting with coordinator for review session, eg. 6 weeks	
<input type="checkbox"/> Review meeting - use Quick Tick System Assessment Checklist to see if all systems components are in place <input type="checkbox"/> Provide initial audit information where available erg. Increase in the numbers of people referred to services, success rate <input type="checkbox"/> Feedback progress to date to the team <input type="checkbox"/> Arrange second review meeting	
<input type="checkbox"/> Second review meeting – use Quick Tick System Assessment Checklist for a rapid assessment of system components <input type="checkbox"/> Arrange presentation of the Excellence Award in Gold Standard Care; ensure the practice receives publicity about its achievement in PCT communication outlets. <input type="checkbox"/> Gain feedback and evaluation from the team	
<input type="checkbox"/> Plan reinforcing activities and support, eg face to face ongoing contacts with the team to review the system and outcomes <input type="checkbox"/> Offer to provide a specialist advisor to run a clinic for a specified period of time in the practice <input type="checkbox"/> Provide new posters to replace other ones on a regular basis.	

## Stage 3: Adherence (reinforcing activities)

Reinforcing activities are vital to ensure that the system is sustained and to maintain the commitment and enthusiasm of the team. Activities reinforcing team commitment to continue providing brief interventions include:

- Identify ways of continually reinforcing with senior management the benefits of referring patients to the NHS Stop Smoking service to offset any negative comments about the service from individual patients. Clinicians tend to remember the negative comment from patients so remind them by providing positive testimonials from their patients.
- Regular newsletters or bulletins highlighting 'best practice'. (Charts and tables of dry statistics generally tend not to be appreciated)
- Quarterly meetings with the team to share ideas and new resources
- Periodic face to face visits to the team to applaud their activity and reinforced their commitment. Clinicians tend to refer their patients to people known to them rather than an unfamiliar service.
- Consider developing an excellence or best practice that you can give to successful teams. (see Yorkshire & Humber Award below)

## I have worked with a team to implement systems but the outcome is disappointing?

If outcomes have not improved with a team, then use the Comprehensive System Assessment Checklist to undertake a more in-depth evaluation of the system to identify problematic areas. Potential problem areas are:

- The team sees the change as an isolated project with a start and an end date, and not as an ongoing initiative to improve their system of care.
- Senior management is not fully committed
- The system has not been implemented with a whole system view, assessing the potential impact on other areas of the practice activities.
- There is a lack of reinforcing activities to maintain team commitment to continue the programme



**SmokeFree**  
Yorkshire and Humber

# Excellence Award

Presented to

For providing  
**Gold Standard Care**  
(stop smoking support)

Signed

Date

Director of Public Health

## Developing systems in mental health

The principles involved in developing systems in mental health facilities are similar to those in other healthcare organisations, however here are areas needing special consideration:

### Ensure that the following are considered when developing the protocol

- Train staff in the clinical and psychosocial elements of tobacco use and on the impact of cessation on mental health and on medication use.
- Assess tobacco use of all patients, entering tobacco dependence as an official diagnoses. Establish a reminder system that prompts clinicians to address tobacco use.
- Devise a reminder system to advise all tobacco users to quit and assess motivation to quit several times throughout the year
- Identify a specific mental practitioner who will be responsible for each person's mental health needs and coordinates all treatment services, including tobacco cessation.
- Include smoking cessation in treatment plans. Work with families on how they can support service users in their efforts to quit smoking
- Provide all tobacco uses who are motivated to quit with interventions
- Ensure that the pharmacy formulary includes both prescription and over the counter tobacco dependence treatment medications
- Compile information about cessation resources, and share with service users /their families
- Ensure the elements of smoking cessation are incorporated in to regular monitoring systems

### In the community

- Raise awareness among partners about disparate smoking rates among people with mental health problems
- Provide tools and self help materials that help all people with mental illness assess their own progress in stopping non-smoking
- Broaden efforts to help service uses abstain from tobacco use by identifying other partners who can provide follow -up and resources, eg all outpatient programmes, case managers, consumer-operated services, private psychiatric facilities, national quit lines.

# Templates

## Quick Tick System Assessment Checklist

### Quick Tick System Assessment Checklist

- Senior management is committed to providing brief advice to all patients when appropriate.
- A programme champion and a coordinator have been identified to ensure that the team continues to provide brief advice.
- A written protocol is available specifying named individuals for various tasks:
- The whole team is willing to be trained in giving effective brief advice, eg ABC approach:
- All team members are willing to provide confidence boosting brief advice:
- Posters promoting stop smoking support are displayed in public and practice areas:
- All entrances to the building are smokefree:
- Stop smoking resources are available in an organised manner, eg filed and labeled so that the team know appropriate resources for diverse groups:
- Information about effective and bogus therapies is available:
- Information about the local NHS Stop Smoking Service is available
- An audit system monitors outcomes and results are fed back to the team on a regular basis to reinforce team commitment:
- Relevant team members are encouraged to attend update sessions on stopping smoking:



Does the protocol comply with the NHS Stop Smoking Service's and Monitoring Guidance?	Yes	No
Are there reminders on the practice software to ask about smoking?	Yes	No
Are all smokers advised to stop?	Yes	No
Are patients who are advised to stop referred into the local stop smoking service or an in-house adviser?	Yes	No
Are there any issues for the practice in earning QoF points?	Yes	No

#### 4. Teamwork

Are all team members committed to helping smokers to quit?	Yes	No
Are tasks for helping smokers shared out amongst the team?	Yes	No
Do you have an in-house advisor offering stop smoking support?	Yes	No
If not, would any of your staff like to become accredited advisers able to provide intensive quality support to smokers?	Yes	No

#### 5. Training

Have all practice staff received brief intervention training?	Yes	No
Due to the importance of all team members involved in helping smokers quit, will all staff be able to attend training or refresher training on smoking cessation?	Yes	No
Are there any particular issues in relation to stop smoking on which that staff would like training?	Yes	No

If yes, please specify:

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#### 6. Environment

Are the practice grounds smoke free?	Yes	No
Does the practice have the mandatory smokefree legislation signage displayed on public entrances?	Yes	No

Are posters on display in the reception area promoting the stop smoking support available? Yes No

Are posters on display in the patient consultation rooms promoting the stop smoking support available? Yes No

Are posters changed at least every 3 – 4 months? Yes No

## **7. Resources**

Does the practice have self-help stop smoking leaflets? Yes No

Does the practice have resources for ethnic patients? Yes No

Does the practice have resources for pregnant smokers? Yes No

Does the practice have stop smoking leaflets for young people? Yes No

Are the resources neatly organised so that staff can easily find appropriate resources to meet the individual needs of patients? Yes No

## **8. Therapies**

Is nicotine replacement therapy, Zyban or Champex recommended to patient's planning to stop smoking? Yes No

Do you make recommendations regarding the above in accordance with the NICE guidelines? Yes No

Is there information available about 'stop smoking treatments without evidence of effectiveness, eg acupuncture, hypnotism? Yes No

Does your practice prescribe cessation aids as long as patient is receiving support, even if the support is provided elsewhere? Yes No

## **9. NHS Stop Smoking Service**

Does the practice have on display information about the service for patients to take away with them? Yes No

Is the team aware of the success rate of the service?	Yes	No
Is the team aware of treatment options provided by the service ?	Yes	No
Does the practice refer patients to the NHS stop smoking service?	Yes	No
Are pregnant smokers referred to the NHS stop smoking service?	Yes	No
Are pre-op patients who smoke referred to the service?	Yes	No

### 10. Feedback

Is patient satisfaction with the stop smoking support evaluated? If yes, <u>how</u> ?	Yes	No
Is feedback provided to the team about patient satisfaction? If yes – how?	Yes	No
Is patient feedback used to improve your programme? If yes, <u>how</u> ?	Yes	No
Does the practice welcome ongoing support from the NHS Stop Smoking Service to help them sustain their stop smoking support?	Yes	No

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**Identify gaps and list agreed actions to fill gaps below:**

Action Plan	Lead person
Action 1	
Action 2	
Action 3	
Action 4	
Action 5	
Action 6	

## Template Protocol – Brief Advice

Component	Tasks
<b>Senior level support</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will 'Champion' the smoking cessation work in the department?</li> <li><input type="checkbox"/> Who will 'co-ordinate' the smoking cessation work in the department?</li> </ul>
<b>Assessment and recording of smoking status:</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will ask about smoking status?</li> <li><input type="checkbox"/> How and where will smoking status be recorded?</li> <li><input type="checkbox"/> Who will be responsible for recording smoking status?</li> <li><input type="checkbox"/> How often will patients be asked about their smoking status?</li> <li><input type="checkbox"/> What information will be recorded? erg               <ul style="list-style-type: none"> <li><input type="checkbox"/> Non smoker</li> <li><input type="checkbox"/> Ex smoker – date stopped</li> <li><input type="checkbox"/> Current smoker – how long smoked – previous quit attempts</li> </ul> </li> <li><input type="checkbox"/> Who will communicate this information to               <ul style="list-style-type: none"> <li><input type="checkbox"/> existing staff:</li> <li><input type="checkbox"/> new staff:</li> </ul> </li> </ul>
<b>Brief advice</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will give brief cessation advice (30-60 sec)?</li> <li><input type="checkbox"/> Where will this be recorded?</li> </ul>
<b>Referral</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will be responsible for referring patients to the local stop smoking services?</li> <li><input type="checkbox"/> How will this person receive the referral information? eg by referral slips, a book at reception</li> <li><input type="checkbox"/> How will the referrals be sent to the local Stop Smoking Service? erg. fax / phone / email</li> <li><input type="checkbox"/> How often will referrals be sent? erg. as they occur / twice a week</li> <li><input type="checkbox"/> Who will communicate the referral procedure to: a) existing staff b) new staff</li> </ul>
<b>Resources/promotion</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will be responsible for selecting a range of smoking interventions resources?</li> </ul>

	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will be responsible for displaying posters promoting smoking cessation?</li> <li><input type="checkbox"/> How often will displays / posters be changed?</li> <li><input type="checkbox"/> Where will resources be kept?</li> <li><input type="checkbox"/> Who will be responsible for checking stocks of resources and reordering?</li> <li><input type="checkbox"/> Who will communicate this information to <ul style="list-style-type: none"> <li><input type="checkbox"/> a) existing staff</li> <li><input type="checkbox"/> b) new staff?</li> </ul> </li> </ul>
<b>Training</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Who will attend training (20 minutes) for brief advice? <i>(the whole team including medical staff should attend this session)</i></li> <li><input type="checkbox"/> Is any team member interested in training in providing intensive support?</li> </ul>
<b>Therapies</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Is there credible information available on effective therapies to give to patients?</li> <li><input type="checkbox"/> Is there information about treatments that have not been found to be effective, eg acupuncture, hypnotherapy?</li> </ul>
<b>Audit and Feedback</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> What information will be collected? eg. <ul style="list-style-type: none"> <li><input type="checkbox"/> % of smokers whose smoking status is recorded</li> <li><input type="checkbox"/> % of smokers offered medical advice to stop</li> <li><input type="checkbox"/> % of smokers referred to local Stop Smoking Service</li> <li><input type="checkbox"/> Patient satisfaction with information provided</li> </ul> </li> <li><input type="checkbox"/> How often will the audit be carried out?</li> <li><input type="checkbox"/> Will information regarding referrals be followed up? (this could be done by liaising with the local NHS Stop Smoking Service)</li> <li><input type="checkbox"/> Who would follow up the outcome of referrals?</li> <li><input type="checkbox"/> How often would this be done?</li> <li><input type="checkbox"/> How will feedback be given to the team?</li> <li><input type="checkbox"/> What additional reinforcement activities would the team like from the NHS Stop smoking Service to reinforce its commitment to providing brief interventions to patients?</li> </ul>

## Template Protocol – Brief Interventions

Area of work	Tasks
Senior level support	<ul style="list-style-type: none"> <li>• Who will 'Champion' the smoking cessation work in the department?</li> <li>• Who will 'co-ordinate' the smoking cessation work in the department?</li> </ul>
Assessment and recording of smoking status:	<ul style="list-style-type: none"> <li>• Who will ask about smoking status?</li> <li>• How and where will smoking status be recorded?</li> <li>• Who will be responsible for recording smoking status?</li> <li>• How often will patients be asked about their smoking status?</li> <li>• What information will be recorded? e.g               <ul style="list-style-type: none"> <li>➤ Non smoker</li> <li>➤ Ex smoker – date stopped</li> <li>➤ Current smoker – how long smoked – previous quit attempts</li> </ul> </li> <li>• Who will communicate this information to a) existing staff b) new staff?</li> </ul>
Brief advice / brief interventions	<ul style="list-style-type: none"> <li>• Who will give brief cessation advice (30-60 sec)?</li> <li>• Where will this be recorded?</li> <li>• Who will have more in-depth discussions (5-10 minute) with patients regarding their smoking?</li> <li>• Will this be in a clinic setting?</li> <li>• Will this be with specific targeted patients? How will those patients be identified?</li> </ul>
Referral	<ul style="list-style-type: none"> <li>• Who will be responsible for referring patients to the local stop smoking services?</li> <li>• How will this person receive the referral information? e.g. by referral slips, a book at reception</li> <li>• How will the referrals be sent to the local Stop Smoking Service? e.g. fax / phone / email</li> <li>• How often will referrals be sent? e.g. as they occur / twice a week</li> <li>• Who will communicate the referral procedure to a) existing staff b) new staff</li> </ul>
Resources and promotion	<ul style="list-style-type: none"> <li>• Who will be responsible for selecting a range of resources?</li> <li>• Who will be responsible for displaying posters promoting smoking cessation?</li> <li>• How often will displays / posters be changed?</li> <li>• Where will resources be kept?</li> <li>• Who will be responsible for checking stocks of resources and reordering?</li> </ul>

	<ul style="list-style-type: none"> <li>• Who will communicate this information to: a) existing staff b) new staff?</li> </ul>
Training	<ul style="list-style-type: none"> <li>• Who will identify training needs and arrange / administer training?</li> <li>• Who will attend Brief Advice (20 min) session? (all medical staff should attend this session)</li> <li>• Who will attend Brief Intervention (3 hr) session? (this session is for staff who would have the time to have a more in-depth (5-10 minute) discussion with a patient about their smoking)</li> </ul>
Therapies	<ul style="list-style-type: none"> <li>• Who will provide information on use of treatment?</li> </ul>
Audit and Feedback	<ul style="list-style-type: none"> <li>• What information will be collected? e.g. <ul style="list-style-type: none"> <li>➤ % of smokers whose smoking status is recorded</li> <li>➤ % of smokers offered medical advice to stop</li> <li>➤ % of smokers referred to local SSS</li> <li>➤ Patient satisfaction with information provided</li> </ul> </li> <li>• How often will the audit be carried out?</li> <li>• Will information regarding referrals be followed up? (this could be done by liaising with the local SSS)</li> <li>• Who would follow up the outcome of referrals?</li> <li>• How often would this be done?</li> <li>• How will feedback be given to the team?</li> </ul>

## Template Protocol – In-house stop smoking support

Area of work	Tasks
Senior level support	<ul style="list-style-type: none"> <li>• Who will 'Champion' the smoking cessation work in the department?</li> <li>• Who will 'co-ordinate' the smoking cessation work in the department?</li> </ul>
Assessment and recording of smoking status:	<ul style="list-style-type: none"> <li>• Who will ask about smoking status?</li> <li>• How and where will smoking status be recorded?</li> <li>• Who will be responsible for recording smoking status?</li> <li>• How often will patients be asked about their smoking status?</li> <li>• What information will be recorded? e.g               <ul style="list-style-type: none"> <li>➤ Non smoker</li> <li>➤ Ex smoker – date stopped</li> <li>➤ Current smoker – how long smoked – previous quit attempts</li> </ul> </li> <li>• Who will communicate this information to a) existing staff b) new staff?</li> </ul>
Brief advice / brief interventions	<ul style="list-style-type: none"> <li>• Who will give brief cessation advice (30-60 sec)?</li> <li>• Where will this be recorded?</li> <li>• Who will have more in-depth discussions (5-10 minute) with patients regarding their smoking?</li> <li>• Will this be in a clinic setting?</li> <li>• Will this be with specific targeted patients? How will those patients be identified?</li> </ul>
Smoking cessation support programmes for patients	<ul style="list-style-type: none"> <li>• Who will assess patients for nicotine dependency to ensure an appropriate level of support can be offered?</li> <li>• Who will deliver smoking cessation support programmes in the practice?</li> <li>• How will the in house advisor receive referrals?</li> <li>• Will support be offered in a specific clinic or within routine appointments?</li> <li>• Who will be responsible for referring patients to the local NHS stop smoking services?</li> <li>• How will this person receive the referral information? e.g. by referral slips, a book at reception</li> <li>• How will the referrals be sent to the local Stop Smoking Service? e.g. fax / phone / email</li> <li>• How often will referrals be sent? e.g. as they occur / twice a week</li> <li>• Who will communicate the referral procedure to: a) existing staff b) new staff?</li> </ul>
Resources	<ul style="list-style-type: none"> <li>• Who will be responsible for selecting a range of</li> </ul>

and promotion	<p>resources?</p> <ul style="list-style-type: none"> <li>• Who will be responsible for displaying posters promoting smoking cessation?</li> <li>• How often will displays / posters be changed?</li> <li>• Where will resources be kept?</li> <li>• Who will be responsible for checking stocks of resources and reordering?</li> <li>• Who will communicate this information to: a) existing staff b) new staff?</li> </ul>
Training	<ul style="list-style-type: none"> <li>• Who will identify training needs and arrange / administer training?</li> <li>• Who will attend Brief Advice (20 min) session? (all medical staff should attend this session)</li> <li>• Who will attend Brief Intervention (3 hr) session? (this session is for staff who would have the time to have a more in-depth (5-10 minute) discussion with a patient about their smoking)</li> <li>• Who will attend registered advisor training? (this session is for staff who will be supporting patients through their quit attempt, assessing nicotine dependence and recommending treatment)</li> </ul>
Therapies	<ul style="list-style-type: none"> <li>• Who will be responsible for assessing patients for nicotine dependency and treatment?</li> <li>• Who will provide information on use of treatment?</li> <li>• How will information on use of treatment be communicated to patients? e.g. leaflet / demonstrated by a member of staff / information sheet</li> <li>• How will patients obtain treatment?</li> <li>• Who will write the protocol for providing treatment?</li> <li>• Where will the protocol be kept?</li> <li>• How will the protocol be communicated to: a) existing staff b) new staff?</li> </ul>
Audit and Feedback	<ul style="list-style-type: none"> <li>• What information will be collected?</li> </ul> <p>e.g.</p> <ul style="list-style-type: none"> <li>➤ % of smokers whose smoking status is recorded</li> <li>➤ % of smokers offered medical advice to stop</li> <li>➤ % of smokers referred to local Stop Smoking Service</li> <li>➤ % of smokers provided with treatment</li> <li>➤ Numbers of patients seen by in house advisor and outcome</li> <li>➤ Patient satisfaction with information provided</li> </ul> <ul style="list-style-type: none"> <li>• How often will the audit be carried out?</li> <li>• Will information regarding referrals be followed up? (this could be done by liaising with the local SSS)</li> </ul>

	<ul style="list-style-type: none"><li>• Who would follow up the outcome of referrals?</li><li>• How often would this be done?</li><li>• How will feedback be given to the team?</li></ul>
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## Differing Types of Activity in Brief Advice, Brief Interventions and In-House Support

	<b>Brief advice</b>	<b>Brief intervention</b>	<b>In-house support</b>
Adherence to NICE guidance	<ul style="list-style-type: none"> <li>• The practice records smoking status and conducts a 30 sec – 2 min intervention.</li> <li>• The intervention should provide basic information about available support and, where appropriate, a referral or encouragement to self refer to local NHS SSS</li> </ul>	<ul style="list-style-type: none"> <li>• The practice records smoking status and conducts a 5 - 10 min intervention. This might be with specific patient groups relating the patients smoking to their health condition.</li> <li>• Interventions should provide brief details about available services and treatment options and a referral to the local NHS SSS where appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Practice records smoking status, and, following assessment, either provides in house smoking cessation support in line with NICE guidance or refers to local NHS SSS where appropriate.</li> <li>• Support should be in line with DH guidance for the provision of NHS Stop Smoking Services and should include the provision of pharmacological treatment.</li> </ul>
<p><b>Senior Level Commitment</b></p> <p><i>Improvement in a system is highly dependent on commitment from senior management. To ensure commitment, a highly respected member of the team needs to volunteer to be 'Programme Champion'. In addition a</i></p>	<ul style="list-style-type: none"> <li>• Programme Champion identified</li> <li>• Programme Co-ordinator identified. The co-ordinator should have sufficient credibility to maintain enthusiasm, overcome obstacles and gain the support of staff at all levels. They will assume responsibility for ensuring that everybody does their</li> </ul>	<ul style="list-style-type: none"> <li>• Programme Champion identified</li> <li>• Programme Co-ordinator identified. The co-ordinator should have sufficient credibility to maintain enthusiasm, overcome obstacles and gain the support of staff at all levels. They will assume responsibility for ensuring that everybody does their</li> </ul>	<ul style="list-style-type: none"> <li>• Programme Champion identified</li> <li>• Programme Co-ordinator identified. The co-ordinator should have sufficient credibility to maintain enthusiasm, overcome obstacles and gain the support of staff at all levels. They will assume responsibility for ensuring that everybody does their tasks and support is delivered consistently and</li> </ul>

<p><i>'Programme Co-ordinator' should be identified to work with the local SCIP facilitator. Both Champion and Co-ordinator should feel deeply committed to helping smokers and should not volunteer because of external pressure</i></p>	<p>tasks and support is delivered consistently and effectively.</p> <ul style="list-style-type: none"> <li>• A regular communication pathway is established between the Co-ordinator and Champion to review progress and assess risk.</li> </ul>	<p>tasks and support is delivered consistently and effectively.</p> <ul style="list-style-type: none"> <li>• A regular communication pathway is established between the Co-ordinator and Champion to review progress and assess risk.</li> </ul>	<p>effectively.</p> <ul style="list-style-type: none"> <li>• A regular communication pathway is established between the Co-ordinator and Champion to review progress and assess risk.</li> </ul>
<p><b>Incentives</b></p> <p><i>Smoking cessation interventions will only be delivered consistently when strong incentives are felt by everyone in the team, otherwise delivery of interventions will depend on the memory, motivation and time available of keen individuals within the team</i></p>	<ul style="list-style-type: none"> <li>• Example of best practice</li> <li>• QOF points</li> <li>• Locally agreed targets</li> <li>• Time efficient ref. NNT</li> <li>• Improvement in patient health and continuity of care</li> <li>• Reducing cost of treating smoking related diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Example of best practice</li> <li>• QOF points</li> <li>• Locally agreed targets</li> <li>• Time efficient ref. NNT</li> <li>• Improvement in patient health and continuity of care</li> <li>• Reducing cost of treating smoking related diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Example of best practice</li> <li>• QOF points</li> <li>• Locally agreed targets</li> <li>• Time efficient ref. NNT</li> <li>• Locally enhanced service provision reward</li> <li>• Improvement in patient health and continuity of care</li> <li>• Reducing cost of treating smoking related diseases</li> </ul>
<p><b>Protocol</b></p> <p><i>A written protocol is essential as it ensures that all team members are clear on its services in</i></p>	<ul style="list-style-type: none"> <li>• A protocol for raising the issue of smoking, recording smoking status and a clear referral pathway is written and communicated to all staff members including new</li> </ul>	<ul style="list-style-type: none"> <li>• A protocol for raising the issue of smoking, recording smoking status, identifying patients most at risk from smoking related ill health for further discussion and a clear</li> </ul>	<ul style="list-style-type: none"> <li>• A protocol for raising the issue of smoking, recording smoking status, assessing nicotine dependency and a clear referral pathway is written and communicated to all staff</li> </ul>

<p><i>helping smokers stop. Then the team can go on to determine who is responsible for various tasks. The protocol should be tailored to meet the needs of the team.</i></p>	<p>members of staff</p>	<p>referral pathway is written and communicated to all staff members including new members of staff</p>	<p>members including new members of staff.</p> <ul style="list-style-type: none"> <li>• A protocol for delivering support through out a quit attempt, in line with DH standards, is written and communicated to all trained smoking cessation advisors in the practice.</li> </ul>
<p><b>Teamwork</b></p> <p><i>Teamwork is crucial for delivering any type of preventive services. It ensures that responsibilities are shared out among staff so that the burden of tasks does not fall only on one person. Teamwork helps overcome time constraints the most common barrier in delivering smoking cessation.</i></p>	<ul style="list-style-type: none"> <li>• Tasks are delegated to specific team members and everyone is aware of their role.</li> <li>• All the team are involved with conducting tasks in a time efficient manner.</li> </ul>	<ul style="list-style-type: none"> <li>• Tasks are delegated to specific team members and everyone is aware of their role.</li> <li>• All the team are involved with further skills and knowledge being developed within the team.</li> </ul>	<ul style="list-style-type: none"> <li>• Tasks are delegated to specific team members and everyone is aware of their role.</li> <li>• All the team are involved with more advanced skills and knowledge being developed within the team</li> </ul>
<p><b>Resources</b></p> <p><i>User friendly resources enhance patient efficacy in stopping as well as</i></p>	<ul style="list-style-type: none"> <li>• Posters are displayed in the waiting area promoting smoking cessation support</li> <li>• Information about local services are available for staff</li> </ul>	<ul style="list-style-type: none"> <li>• Posters are displayed in the waiting area promoting smoking cessation support</li> <li>• Information about local services are available for staff</li> </ul>	<ul style="list-style-type: none"> <li>• Posters are displayed in the waiting area promoting smoking cessation support</li> <li>• Information about local services are available for staff to</li> </ul>

<p><i>supplementing the advice of healthcare providers.</i></p>	<p>to give to patients</p>	<p>to give to patients</p> <ul style="list-style-type: none"> <li>• Specific information relating smoking to a range of health conditions are used in appropriate clinics e.g. diabetes clinic</li> </ul>	<p>give to patients</p> <ul style="list-style-type: none"> <li>• Specific information relating smoking to a range of health conditions are used in appropriate clinics e.g. diabetes clinic</li> <li>• A range of resources to assist a patients in a quit attempt are used by the trained smoking cessation practitioner</li> </ul>
<p><b>Therapies</b></p> <p><i>Knowledge of a variety of treatment for stopping smoking and how to access treatment helps establish a patient centred approach. NICE recommend that smokers should be encouraged to use pharmacological therapies to aid a cessation attempt.</i></p>	<ul style="list-style-type: none"> <li>• GPs and other staff members are aware of smoking cessation treatment options and their success rates.</li> </ul>	<ul style="list-style-type: none"> <li>• GPs and other staff members are aware of smoking cessation treatment options, how to use the range of treatments and their success rates.</li> </ul>	<ul style="list-style-type: none"> <li>• The practice smoking cessation advisor has an in depth understanding of smoking cessation treatment options, how to select appropriate treatment for patients, how the treatments differ in their mode of action, how to use the range of treatments and their success rates.</li> <li>• Patients are assessed for their suitability for treatment and a protocol for obtaining treatment is established.</li> </ul>

<p><b>NHS Stop Smoking Service</b></p> <p><i>Support from the local NHS SSS is essential to improve the continuity of care from the healthcare setting to the community. Not only do services enhance smokers efficacy in stopping, it also increases healthcare providers motivation to deliver smoking cessation interventions knowing that the burden of helping someone stop is not totally on their shoulders.</i></p>	<ul style="list-style-type: none"> <li>• GPs and other staff members are aware of their local NHS Stop Smoking Service, the range of clinics offered, their success rates and how to make a referral.</li> </ul>	<ul style="list-style-type: none"> <li>• GPs and other staff members are aware of their local NHS Stop Smoking Service, the range of clinics offered, their success rates and how to make a referral.</li> <li>• Staff can briefly describe the treatment programmes to patients.</li> </ul>	<ul style="list-style-type: none"> <li>• GPs and other staff members are aware of their local NHS Stop Smoking Service, the range of clinics offered, their success rates and how to make a referral. Staff can briefly describe the treatment programmes to patients</li> <li>• Opportunity for staff members to be trained as a smoking cessation advisor and further develop skills to meet their own professional development.</li> </ul>
<p><b>Feedback</b></p> <p><i>Feedback is a vital component for maintaining momentum in making changes and enthusiasm of the team. It is well known that what gets measured is more likely to be done.</i></p>	<ul style="list-style-type: none"> <li>• Internal feedback on how successful the local protocol has been.</li> <li>• Internal information re. recording of smoking status of patients and numbers referred to stop smoking service</li> <li>• External information available from local SSS re. referrals received and outcome.</li> </ul>	<ul style="list-style-type: none"> <li>• Internal feedback on how successful the local protocol has been.</li> <li>• Internal information re. recording of smoking status of patients and numbers referred to stop smoking service</li> <li>• External information available from local SSS re. referrals received and outcome.</li> </ul>	<ul style="list-style-type: none"> <li>• Internal feedback on how successful the local protocol has been.</li> <li>• Internal information re. recording of smoking status of patients and numbers referred to stop smoking service</li> <li>• Internal feedback of the numbers of people accessing in house services and outcome</li> <li>• External information available from local SSS re.</li> </ul>

			referrals received and outcome.
<p><b>Training</b></p> <p>All training offered should meet the HDA training standards</p> <p><i>Equipping healthcare providers with knowledge and skills in providing smoking cessation is vital to give them the confidence to help smokers stop smoking.</i></p>	<ul style="list-style-type: none"> <li>• In house 30 minute session for all staff</li> </ul>	<ul style="list-style-type: none"> <li>• In house 30 minute session for all staff</li> <li>• L1 smoking training for designated team members (1/2 day)</li> </ul>	<ul style="list-style-type: none"> <li>•</li> <li>• In house 30 minute session for all staff</li> <li>• L1 smoking training for designated team members</li> <li>• L2 smoking training for in house smoking advisor. (2-2½ days)</li> </ul>

## Sample SCIP Action Plan

Objective	Action	Lead	Timescale	Outcome
<b>1. Determine the scope of SCIP</b>	<p>1. Decide which practices SCIP should be piloted in and why.</p> <p>2. Use local health intelligence to select practices accordingly</p>			
<b>2. Allocate adequate resources to implement SCIP</b>	<p>1. To implement SCIP in 4 GP practices at any one time will require the following for each practice: 6 visits over a period of 20 weeks for a max of 2 hours per visit. This equates to 2.4 hours/week.</p> <p>2. Review current staff workloads and if possible reorganize workloads and allocate SCIP to nominated specialists.</p> <p>3. If current capacity insufficient consider recruitment of bank staff to cover.</p> <p>4. Ensure staff responsible for delivering SCIP are appropriately trained.</p>			
<b>3. Secure senior level support and promote SCIP</b>	<p>1. Discuss SCIP at team meeting with identified practices to further obtain their support.</p>			
<b>4. Plan and implement SCIP visits</b>	<p>1. Develop plan/timetable of visits to 4 pilot areas</p>			

	<p>2. Review local intelligence data prior to each visit.</p> <p>3. Implement SCIP visits</p> <p>4. Continue quarterly support contact following initial SCIP visits.</p> <p>5. Feedback outcome and referral data at updates.</p>			
<p><b>5. Evaluate SCIP and make necessary changes</b></p>	<p>1. Audit changes in pilot practices (page 15 of manual)</p> <p>2. Develop plan/timetable of further visits dependant upon review of SCIP to roll out across the patch.</p> <p>3. Use practices awarded with gold standard as champion practices to put in PCT newsletters etc.</p>			

## Case Study

### Sheffield 50

The Sheffield NHS Stop Smoking Service set up in 1999 had trained over 600 healthcare providers to provide stop smoking groups within the four PCT areas. Initially the approach was successful, with the Service achieving its Department of Health 4 week quit targets.

In 2003 South East Sheffield PCT three-year target for 4 week quits was increased to 2840. During the first year only 16% of the target was achieved (452). The PCT employed a stop smoking specialist development worker to help achieve its target.

The remit of the SDW was to examine the possibilities of providing a one to one service in primary care and the community as there had been a shift in service demand with smokers preferring to attend one to one sessions rather than groups. To achieve this aim, 32 GP practices and 26 pharmacies in the PCT area were invited to complete the Smoking Cessation in Practice (SCIP) questionnaire to identify their current system for delivering stop smoking support.

The review identified a number of communication, information and resource issues including confusion about how to refer to the specialist service, where to send the referrals to and how to access services. There was also a need to providing ongoing motivation, support and continuous feedback and monitoring in order to sustain systems for providing support.

A number of tasks were carried out to support GP practices and pharmacies to develop a sustainable system, eg providing referral pads, posters, leaflets, brief intervention training, providing guidance on developing protocols for running one to one sessions. New advisors were given intensive support and current divisors update sessions. Follow up visits were carried out every six months.

### Outcome

There was a significant increase in four week quits year on year: In the first year there was a 92% increase in four weeks quits reported by the NHS Stop Smoking Services and a 112% increase over the two year period. The other PCTs in the district did not experience the same dramatic increase in four weeks quits.

Year	Four week quits
2003/04	452
2004/05	859 (92% increase
2005/06	962 (112% increase over 2 years

### Lessons learned

According to the development worker, the key to success was supporting GP practices and pharmacies in developing sustainable systems. This includes training, support and resources, good communication, monitoring and feedback in order for the work to be valued and sustained. Regular contact with the teams is essential to sustain effective high quality services.

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## Selected literature review

Independent Task Force on Community Preventive Services: Guide to Community Preventive Services. Systematic Reviews and Evidence based Recommendations. [www.thecommunityguide.org/tobacco](http://www.thecommunityguide.org/tobacco). Updated 2003

### **Conclusion: Health care provider education alone**

There is *insufficient evidence* to determine the effectiveness of provider education interventions when implemented alone in increasing the number of people who quit smoking. Though education alone is not harmful, no benefits have been identified.

### **Conclusion: Provider system interventions**

There is *sufficient evidence* of effectiveness of provider system interventions in increasing the number of providers who advise their clients to quit smoking.

### **Conclusion: Health care provider systems, provider education and patient information**

There is *strong evidence* of effectiveness of multi-component interventions including provider systems, provider education and patient information in increasing the number of providers who advise their clients to quit smoking and in increasing the number of clients who quit.

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**Simplicity matters: Using system-level changes to encourage clinician intervention in helping tobacco users quit: Revell C, Schroeder S. Nicotine & Tobacco Research 2005; 7 (supple 1) April 67-69.**

### **Conclusion:**

Mobilising large armies of clinicians of all kinds offers hope of driving down the number of tobacco users dramatically. *This requires creative changes in the system in which these professionals operate and changes in institution practices.* Education and training alone is clearly not the answer to changing practitioner behaviour. The systems must be optimised to encourage clinicians' behaviour change.

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**GPs confidence in and barriers to implementing smoking cessation activities: Edwards D et al. Australian J Primary Health: 12; 3: p117**

### **Conclusion:**

Confidence and system barriers were reported as the most common factors that impeded greater provision of smoking cessation activities. These two things must be addressed to increase rates of interventions provided by professional groups.

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**System changes to improve health and healthcare: Keller P et al. Nicotine & Tobacco research 2005; 7 (supple 1) S5 – 8.**

**Conclusion:** Interventions that target only clinicians and not the systems in which they practice will be limited in their effectiveness and reach.

**Direct observation of smoking cessation activities in primary care practice: Ellerbeck E, et al. J Family Practice, 2001: 50, 8.**

**Conclusion:**

Smoking cessation practices vary widely in primary care offices. Strategies are needed to assist physicians with incorporating systematic approaches to maximise smoking cessation rates.

*More comprehensive and efficient management of nicotine dependence may be possible if physicians address the infrastructure in their offices that can support smoking cessation activities.*

Efforts should be directed towards identifying barriers to system changes and to helping teams integrate effective and efficient smoking cessation systems in their practice.

**Clinical interventions in Tobacco Control: National Cancer Institute Training Programme for Healthcare Providers: Manley M. et al. Smoking and Tobacco Monograph No 5.****Conclusion:**

Clinical interventions in tobacco control are most effective when practiced by more than one health professional in an office, when the intervention is incorporated into routine office systems and when entire office teams are trained, rather than just those delivering the intervention.

**Training health professionals in smoking cessation. Lancaster T, Silagy C, Fowler G: Cochrane Database of Systematic Reviews. 2007****Conclusions:**

Further studies of interventions offered by physicians are unlikely to yield new information about the role of brief advice. *Work is now required to develop strategies to increase the frequency with which smokers are identified and offered advice and support.*

**How can we increase the involvement of primary healthcare in the treatment of tobacco independence: Anderson P et al. Addiction 2004; 99; 3: 299-312****Conclusion:**

The provision of education interventions for practitioners in combination with systematic outreach practice-based support is likely to be the most effective strategy to increase smoking quit rates throughout primary healthcare.

**Is Some Provider Advice on Smoking Cessation Better Than No Advice? An Instrumental Variable Analysis of the 2001 National Health Interview Survey**

Bao Y, Duan N, Fox S. *Health Service research* 2006 Dec: 41 (6) 2114.

Conclusion: Provider advice delivered in routine practice settings has a substantial effect on the success rate of smoking cessation among smoking patients. Providing advice consistently to all smoking patients, compared with routine care, is more effective than doubling the excise tax and, in the longer run, likely to outperform other tobacco control policies such as banning smoking in private workplaces.